COVID-19 DISABILITY FORM

Please answer the questions on this form to help physicians provide you with proper medical treatment, in case you need to go to the hospital for COVID-19 related symptoms. Complete as many of the questions as possible.

What is your name? _____ Date _____

Is this form being completed by someone else other than you? ☐ Yes ☐ No

☐ Legal guardian ☐ Community Service Provider Staff ☐ Family Member ☐ Targeted Case Manager ☐ Other

If you checked yes, what is the person's name _____ Relationship to you _____

Have you been determined eligible for IDD Program Services by a Community Developmental Disability Organization (CDDO)?

☐ Yes ☐ No ☐ I don't know

**** Note to doctors: This means there may be special laws in place to protect me and a special process needs to be followed if my usual decision maker/guardian requests to withhold or withdraw life sustaining treatment. Please check in with your institutions social worker or risk management department to be sure the appropriate process is being followed.*

How do you communicate best? (Check all that apply)

☐ Talking ☐ Writing or typing things down

☐ Pictures ☐ Using sign language

☐ Pointing to words ☐ Using a voice app

☐ I cannot communicate in a way you will understand, please ask my family, staff or guardian (circle the person)

☐ Other please describe _____

Do you need anything to help you communicate?

(E.g. Assistive devices) ☐ No

☐ Yes (please describe) _____

Does anyone help you communicate? ☐ No

☐ Yes, person's name _____

Do you use any assistive devices for mobility? ☐ No

☐ Yes, list the device(s) _____

Do you have any triggers? *(please describe, e.g. being touched, trauma, doctors of a particular gender, noises, lighting, smells, textures):*

What is your response to triggers?

How can you best be helped when triggered?

What is your typical response to a medical exam?

☐ Fully /Partially Cooperate ☐ Fearful

☐ Aggressive ☐ Resistant

I like it when health professionals (please describe)

I do not like it when health professionals (please describe)

Do you have any medical problems you go to the doctor for?

☐ Yes ☐ No

What are they?

Please list the name of the doctor you would like contacted if you are at the hospital.

Name _____

Phone number _____

Are there any diagnoses, medical problems or behaviors that we should consider as cautions? *(e.g. aggression, biting, pica, aspiration risk):*

Do you have seizures? ☐ No

☐ Yes, *list the type and frequency*

Are there any specific modifications that can help with these cautions?

Do you take any medication at home everyday? ☐ Yes ☐ No

By prescription? ☐ No

☐ Yes, *list the names and dosage*

Over the counter? ☐ No

☐ Yes, *list the names and dosage*

Do you have any allergies? ☐ No ☐ I don't know

☐ Yes, *please list*

Do you use tobacco *(e.g. cigarettes, cigars or chewing tobacco)*?

☐ Yes, please list

How often?

☐ No

Do you use any other drugs *(e.g. marijuana, cocaine, or opiates)*?

☐ Yes, please list

☐ No

Do you use alcohol? ☐ No ☐ Yes How much do you use in a week?

Who can we talk to about medical problems if you can't answer questions?

Name

Phone Number

Do you have a medical representative? ☐ No

☐ Yes Name

Phone Number

Who do you trust to make medical decisions if you aren't able to?

Name

Phone Number

I live *(check one box)*

☐ By myself ☐ With my family

☐ With roomates ☐ In a group home

☐ Supported living ☐ Nursing facility

☐ Other *(Please describe)*

Does anyone you know have COVID-19?

☐ Yes ☐ No ☐ I don't know

When were you told the person has COVID-19?

What was the last date you saw this person?

Capacity to consent

☐ Capable/Own guardian ☐ Substitute decision maker ☐ Supported decision making team ☐ Guardian/Conservator

☐ Other *(please describe)* _____ How was this decided? _____

For patients who are their own guardian/have capacity:

Do you have *(check all that apply)* ☐ 1. An advance directive ☐ 2. A medical representative ☐ 3. A living will

If so, please bring a copy of each document to the hospital

If while you are in the hospital you can't breathe on your own, do you want a machine to help breathe for you? *(Mechanical ventilation)*

☐ Do you not want it at all

☐ Do you want a trial to see if it is working?

☐ Do you want it for as long as it is needed?

If while you are in the hospital your heart stops, do you want your doctor to try and restart it with pushing on your chest, medications, and electric shocks? (Resuscitation)

☐ Yes ☐ No

If you can't eat or drink like you normally do, do you want liquid food and water to be given to you through a tube to your stomach or in a vein? *(Artificial nutrition/hydration)*

☐ Yes ☐ No

Patient name: _____

Indicate: *(indicate relationship or affiliation)*

☐ Parent ☐ Guardian ☐ Responsible person

Name _____

Address _____

City, State _____

Telephone _____

Indicate: *(indicate relationship or affiliation)*

☐ Parent ☐ Guardian ☐ Responsible person

Name _____

Address _____

City, State _____

Telephone _____

TCM Name _____ TCM Phone _____

Responsible community service provider agency _____

Responsible community service provider contact name _____

Responsible community service provider emergency phone number _____

This document and the information therein is for general information purposes only and should not be relied upon as a basis for any medical, legal or business decision. Any reliance placed on such information shall be at the user's own risk.

"Adapted from the work of Ballan, M. & Perri, C. (2020). Covid-19 Disability Form. Stony Brook, NY for use within KS IDD services."